STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

CALIFORNIA DEPARTMENT OF FORESTRY FIREFIGHTERS,	)	
Charging Party,	)	Case No. SA-CE-891-S
v.	)	PERB Decision No. 1260-S
STATE OF CALIFORNIA (DEPARTMENT OF FORESTRY AND FIRE PROTECTION),	)	April 20, 1998
Respondent.	)	

Appearances; Carroll, Burdick & McDonough by Ronald Yank and Kassi Berg-Beck, Attorneys, for California Department of Forestry Firefighters; State of California (Department of Personnel Administration) by Robert K. Roskoph, Labor Relations Counsel, for State of California (Department of Forestry and Fire Protection).

Before Caffrey, Chairman; Dyer and Amador, Members.

DECISION

CAFFREY, Chairman: This case is before the Public Employment Relations Board (PERB or Board) on exceptions filed on behalf of the State of California (Department of Forestry and Fire Protection) by the State of California (Department of Personnel Administration) (State or DPA), and by the California Department of Forestry Firefighters (CDFF) to a proposed decision by a PERB administrative law judge (ALJ). The ALJ found that the State violated section 3519(a), (b) and (c) of the Ralph C. Dills Act (Dills Act)[1] when it unilaterally changed the vision care

[1]The Dills Act is codified at Government Code section 3512 et seq. Unless otherwise indicated, all references herein are to the Government Code. Section 3519 states, in pertinent part:

> It shall be unlawful for the state to do any of the following:

benefits of employees represented by CDFF without providing CDFF with notice or the opportunity to meet and confer over the change.

The Board has reviewed the entire record in this case, including the unfair practice charge and complaint, the hearing transcript, the proposed decision and the filings of the parties.[2] The Board concludes that CDFF has failed to demonstrate that there has been a significant impact on the actual vision care benefits received by employees as a result of the State's action. The Board hereby reverses the ALJ's proposed decision and dismisses the unfair practice charge and complaint in accordance with the following discussion.

> (a) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this chapter. For purposes of this subdivision, "employee" includes an applicant for employment or reemployment.
>
> (b) Deny to employee organizations rights guaranteed to them by this chapter.
>
> (c) Refuse or fail to meet and confer in good faith with a recognized employee organization.

[2]CDFF argues that the State's exceptions were untimely filed. Following the granting of an extension of time, the PERB appeals assistant set October 6, 1997, as the final filing date for exceptions in this case. Applying the five-day extension provided by PERB Regulation 32130(c) (PERB regs, are codified at Cal. Code Regs., tit. 8, sec. 31001 et seq.) and established PERB practice and policy, the appeals assistant correctly accepted both CDFF's exceptions, filed on October 7, 1997, and the State's exceptions, filed on October 10, 1997, as timely filed. CDFF's argument is rejected.

BACKGROUND

CDFF is the exclusive representative of employees within State Bargaining Unit 8. For approximately 10 years, Unit 8 employees have been provided with vision care benefits pursuant to their collective bargaining agreement (CBA) with the State. The State provides the benefits through a contact with a private vision care plan. The vision care provision of the parties' August 15, 1987 through June 30, 1988, CBA states, in pertinent part:

> The employer agrees to provide a vision service plan to eligible employees and their dependents. Eligible employees are defined as: (a) All permanent employees appointed half-time or more for over six months; (b) Permanent Intermittent employees who work a minimum of 480 hours in each six-month period ending each June 30 or December 31; or, (c) Limited Term or TAU appointees with prior continuous permanent status.
>
> The vision service plan shall be the State's plan and shall provide for an annual eye examination, frames, and lenses. There will be a $10.00 employee co-payment for eye examinations and a $25.00 employee co-payment for frames and lenses.

The vision care provision of the parties' October 1, 1988 through June 30, 1991, CBA states, in pertinent part:

> The employer agrees to provide a vision service plan to eligible employees and dependents. The vision service plan provided by the State under this Section shall contain the same benefits and services as those in effect on June 30, 1988, with the same employee co-payments ($10, $25), and the employer shall pay 100% of the premium.

The vision care provision of the parties' 1992-95 CBA states, in pertinent part:

> The employer agrees to provide a vision service plan to eligible employees and dependents. The vision service plan provided by the State under this section shall contain the same benefits and services as those in effect on June 30, 1988, with the same employee co-payments ($10, $25) for the examination and materials, and the employer shall pay 100% of the premium per month per eligible employee and dependents when enrolled in the State-sponsored plan.

The parties' 1992-95 CBA expired on June 30, 1995. At the time of the alleged unlawful conduct in this case, the parties were negotiating over a successor CBA. An employer must maintain certain terms and conditions of employment embodied in an expired agreement while the parties are engaged in bargaining over a successor agreement. (State of California (Department of Forestry and Fire Protection (1993) PERB Decision No. 999-S.) It is undisputed that the State was obligated to maintain the vision care benefits embodied in the parties' 1992-95 CBA at the time of the alleged unlawful conduct in this case.

On June 5, 1995, DPA notified CDFF that it had posted an intent to award the new contract to provide Unit 8 employees with vision care benefits to Vision Service Plan (VSP). The contract in effect at that time, which also was with VSP, was scheduled to expire on July 31, 1995. DPA advised that a contract protest had been filed, and that DPA would seek an extension of the existing VSP contract if the protest was not resolved quickly. The new contract was for VSP's Regional Network Plan (RNP), which contained some provisions different from those of the VSP plan provided under the expiring contract. DPA provided CDFF with no

information concerning the RNP or any difference in the provisions of the expiring and the new VSP contracts. The protest was resolved and the new VSP contract went into effect on August 1, 1995.

The parties stipulated that charging party exhibit 8 (CP 8) reflects an accurate summary of the components of the prior VSP plan and the new VSP plan. CP 8 is entitled "State of California Plan Design." The document indicates that plan components involving the employee deductible, the nonmember schedule, the coverage for examinations and lenses, including contact lenses, and the tints and photochromic covered options are identical in the prior and new VSP plans. The document also presents several apparent differences in the plans, including:

- A reduction in the premium paid by the State from $11.94 to $8.98;
- a reduction in the number of California providers participating in the plan from 4,200 to "about 75-85%" of that number;
- a change in the benefit for frames from "$30 wholesale, control on extras" to "$30 wholesale or $75 retail allowance";
- a change in the benefit for cosmetic extras from "Dispensed at a controlled cost" to "Usual and customary charged";
- a change in the "Frame Coverage" from "Wholesale Difference x 2" to U and C [usual and customary] minus $75";
- a change in "Doctor Fees" from "Standard Discounted Fee for Service" to "RNP fixed fees in California";
- a change in "Doctor Fees for Covered Options" from "Discounted" to "No service fee, only for material";

- a change in the "Lab Agreement" from "65 labs in California" to "Limited number of CA Labs."

Charging party exhibit 3 (CP 3) is a copy of a pamphlet entitled "Vision Care Plan Disclosure Statement and Evidence of Coverage." The pamphlet describes the various components of the VSP plan in effect on June 30, 1988, the date specifically referenced in the parties' 1992-95 CBA. Charging party exhibit 2 (CP 2) is a copy of a pamphlet with the same title which describes the various components of the new VSP plan effective August 1, 1995. The pamphlets contain very similar or identical descriptions of employee deductibles, eligibility, plan and service frequencies and benefits for vision examinations and lenses. With regard to the benefit for frames, CP 3 describes the coverage under the June 30, 1988, VSP plan as follows:

> VSP reserves the right to limit the cost of frames provided by its Panel Doctors under the plan. The limit shall be published periodically by VSP to its Panel Doctors and will be set at a level to cover the majority of frames in common use.

CP 2 describes the coverage for frames under the new VSP plan as follows:

> Participating member doctors can charge their usual and customary fees for frames. Participating member doctors are required to maintain a selection of frames which are fully covered under the your [sic] VSP plan.

Both CP 2 and CP 3 include sections which describe benefit limitations. Under the June 30, 1988, VSP plan, CP 3 states:

> This vision service plan is designed to cover **visual needs** rather than **cosmetic materials.** If you select any of the following extras,

the plan will pay the basic cost of the allowed lenses, and the covered person will pay the additional laboratory cost for the extras plus a modest additional fee.

1. Blended lenses
2. Contact lenses
3. Oversize lenses
4. Progressive multifocal lenses
5. The coating of a lens or lenses
6. The laminating of a lens or lenses
7. A frame that costs more than the plan allowance

CP 2 describes benefit limitations under the new VSP plan as follows:

> Your vision plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the plan will pay the basic cost of the allowed lenses and you will be required to pay any additional costs associated with the extras:
>
> 1. Blended lenses
> 2. Contact lenses (except as noted on page 6)
> 3. Oversize lenses
> 4. Progressive multifocal lenses
> 5. Coated or laminated lenses
> 6. A frame that costs more than the plan allowance
> 7. UV protected lenses
> 8. Other optional cosmetic processes

On June 7, 1996, Larry Crabtree (Crabtree), CDFF's statewide rank and file representative, had a regular visit with his eye doctor. Crabtree discussed the new VSP plan with the doctor, and purchased an optional lens coating for $53. He testified that the lens coating would have cost $44 before the change to the new VSP plan.

Dennis Williams (Williams) purchased one pair of glasses for $73 in January 1997. He testified that he purchased two pairs of glasses for "sixty-something dollars" in January 1995. He further testified that when he inquired as to why the one pair of

glasses cost so much, he was told that it was due to an increase in the deductible.

On October 9, 1996, CDFF filed an unfair practice charge alleging that the State violated the Dills Act on August 1, 1995, by unilaterally changing the vision care benefits provided to Unit 8 employees. CDFF asserts that the new VSP plan has resulted in increased costs to employees for lenses, frames and related vision care services. CDFF seeks a remedy ordering the State to establish a trust fund for the benefit of affected employees using the savings the State achieved as a result of the unlawful unilateral change to the new VSP plan. CDFF also asks PERB to order the State to direct VSP to notify providers, including those who no longer provide services under the new VSP plan, "that the old rate per employee has been reinstated."

On November 5, 1996, the PERB Office of the General Counsel issued a complaint alleging that the State violated Dills Act section 3519(a), (b) and (c) when it unilaterally changed to the new VSP plan, resulting in increased employee costs for vision care and a decrease in the number of vision care providers available.

A PERB-conducted settlement conference did not resolve the dispute. A formal hearing before an ALJ was held on April 21, 1997. On August 25, 1997, the ALJ issued a proposed decision finding that the State violated the Dills Act by unilaterally changing the vision care benefits of employees in Unit 8.

DISCUSSION

Statute of Limitations Issue

Under Dills Act section 3514.5,[3] PERB may not issue a complaint based on alleged conduct which occurred more than six months prior to the filing of the unfair practice charge. CDFF filed the instant charge on October 9, 1996.

In a unilateral change case, the statute of limitations contained in section 3514.5 begins to run when the charging party has actual or constructive notice of the respondent's clear intent to implement the alleged change. (The Regents of the University of California (1990) PERB Decision No. 826-H.) Actual or constructive notice occurs when the exclusive representative has been clearly informed of the proposed change. (Marin Community College District (1995) PERB Decision No. 1092.)

DPA asserts that CDFF's October 9, 1996, charge is untimely, noting that the PERB complaint in this case specifically references August 1, 1995, as the date the change in vision care benefits occurred. Further, DPA argues that CDFF had notice of the impending change on June 5, 1995, when DPA advised CDFF that it had posted a notice of intent to award the new VSP contract.

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[3]Dills Act section 3514.5 states, in pertinent part:

> (a) Any employee, employee organization, or employer shall have the right to file an unfair practice charge, except that the board shall not do either of the following: (1) issue a complaint in respect of any charge based upon an alleged unfair practice occurring more than six months prior to the filing of the charge.

DPA's advisory to CDFF on June 5, 1995, of its intent to award the new VSP contract did not provide CDFF with actual or constructive notice of the alleged change in vision care benefits. DPA provided CDFF with no information concerning the specific aspects of the new VSP plan, or any information comparing the prior and new VSP plans. It was not possible for CDFF to discern from the June 5 notification that the new VSP plan involved the changes which form the basis of the instant unfair practice charge. It was not until June 1996, when Crabtree visited his eye doctor, that CDFF first became aware of the possibility that vision care benefits had been changed under the new VSP contract. CDFF filed its unfair practice charge on October 9, 1996, less than six months after it became aware of the alleged change. Therefore, CDFF's unfair practice charge was timely filed.

Unilateral Change Issue

In order to prevail on a unilateral change charge, the charging party must establish that the employer, without providing the exclusive representative with notice or the opportunity to bargain, breached or altered the parties' written agreement or established past practice concerning a matter within the scope of representation, and that the change has a generalized effect or continuing impact on the terms and conditions of employment of bargaining unit members. (Pajaro Valley Unified School District (1978) PERB Decision No. 51

(Pajaro Valley); Grant Joint Union High School District (1982) PERB Decision No. 196.)

The Board recently decided another case in which it was alleged that the State's contract to provide vision care benefits through the new VSP plan constituted an unlawful unilateral change. In State of California (Department of Personnel Administration) (1998) PERB Decision No. 1244-S (DPA (CAPS)), the Board noted that cases involving changes in health benefit plans and health benefit plan administrators present a unique type of unilateral change allegation for several reasons. While health benefits are fundamental elements of the terms and conditions of employment, the actual benefits employees receive are typically provided under a contract between the employer and a health benefit plan. Health benefit plans are dynamic creatures, and minor adjustments in the nature and variety of services and benefits provided to employees under a health plan are a normal, if not constant, occurrence. Also, while different health benefit plans often provide similar arrays of actual services and benefits, they also typically include some variations since no two plans are likely to be identical. In recognition of this, health benefit provisions of CBAs rarely, if ever, contain a comprehensive list of the benefits employees are to receive, and often do not specify a particular health benefit plan to be provided.

In considering alleged unilateral changes in this area, the Board has attempted to balance the bargaining rights and

obligations of parties who have entered into general health benefit CBA provisions with the need to avoid the disruption which would result from requiring negotiations over each and every adjustment in services or benefits offered under a health benefit plan. As a result, the Board has held that a change in health benefit plans or administrators is negotiable only if the change has a material or significant effect or impact on the actual benefits received by employees. (Oakland Unified School District (1980) PERB Decision No. 126; affd. Oakland Unified School Dist, v. Public Employment Relations Bd. (1981) 120 Cal.App.3d 1007, 1012 [175 Cal.Rptr. 105]; Palo Verde Unified School District (1983) PERB Decision No. 321; Trinidad Union Elementary School District/Peninsula Union School District (1987) PERB Decision No. 629 (Trinidad/Peninsula); Savanna School District (1988) PERB Decision No. 671; Oakland Unified School District (1994) PERB Decision No. 1045 (Oakland USD).) It is not enough to theorize or speculate that a change could impact employees. The actual effect on employees, caused by the health benefit-related change, must be shown. (Trinidad/Peninsula.) In Oakland USD, the Board concluded that an unlawful unilateral change had occurred since it was clear that a change in health plan providers had resulted in a material and significant impact on the employee cost of the actual health benefits they received.

As in DPA (CAPS). the State here points to Yuba Community College District (1990) PERB Decision No. 855 (Yuba CCD) in arguing that the status quo is defined by the negotiated language

of the expired CBA, which clearly lists specific vision care benefits to be received by employees. Since these benefits continue to be provided under the new VSP plan, the State asserts that the status quo has been maintained and no unilateral change has occurred.

Yuba CCD is clearly distinguishable from the case at bar. In that case, the parties' contract specified that health benefit coverage would be provided through a specific Blue Cross insurance plan. During the time that the plan had been specified in the contract, several uncontested changes in benefits and plan provisions had been implemented by Blue Cross. The Board concluded that the status quo, therefore, included a regular and consistent pattern of changes in the specified Blue Cross health plan. (Pajaro Valley.) In this case, there is no evidence suggesting that there has been a regular and consistent pattern of changes to the benefits provided to employees pursuant to the vision care provision of the parties' CBA.

As is typical with health benefit provisions, in this case the actual vision care benefits received by employees pursuant to the contract include services and benefits not specifically listed in the current or former CBAs. This array of actual benefits received by employees represents the status quo which the State is bound to maintain. Any unilateral change resulting in a significant impact on these actual benefits, or their cost to employees, may violate the Dills Act, even though the benefits

impacted have never been specifically listed in any of the parties' CBAs.

It is clear that the State entered into a new contract with VSP to provide vision care benefits, a subject within the scope of representation. It is also clear that the State did so without providing CDFF with notice or the opportunity to negotiate. The question presented by this case is whether the change to the new VSP plan had a significant impact on the actual vision care benefits received by employees, or the cost of those benefits to employees. To prevail in this case, CDFF must demonstrate by a preponderance of the evidence[4] that such a significant impact resulted from the change to the new VSP plan.

To meet this burden, CDFF presents evidence in the form of several exhibits and the testimony of various witnesses. CDFF refers to CP 8 as a "smoking gun" exhibit. According to CP 8, the new VSP plan is different from the prior plan in several ways. Among the differences are a reduction in the premium paid by the State, a reduction in the number of participating providers, a change in doctor fees, and a reduction in the number of laboratories participating in the plan. CDFF asserts that these changes have an impact on the vision care benefits received by employees, but speculation concerning the impact of these features of the new VSP plan is insufficient to establish that a

[4]PERB Regulation 32178 states:

> The charging party shall prove the complaint by a preponderance of the evidence in order to prevail.

change has occurred. (Trinidad/Peninsula: DPA (CAPS).) CDFF offers a declaration from Arthur E. Smith (Smith) indicating that he was forced to change his vision care provider because his former ophthalmologist did not accept the new VSP plan. Smith indicates that he found another provider, but he asserts that the loss of the long relationship with his former provider, who "frequently did extra things" for Smith and his family, represents a change in the level of his vision care benefits.

The accessibility of health benefits to employees is an important feature of those benefits. However, the accessibility of benefits is determined by the availability of the benefits themselves, rather than by the availability of an individual provider or health plan through which employees receive the benefits, unless the parties have specified that provider or plan in their agreement. It appears that the vision care benefits provided under the prior VSP plan continue to be readily accessible to Smith under the new VSP plan, albeit through a provider he likes less than his former ophthalmologist. Therefore, Smith's declaration does not demonstrate that there has been a significant impact on actual vision care benefits as a result of the reduction in the number of providers under the new VSP plan.

CDFF has presented no evidence from which it can be concluded that the reduction in the number of providers and laboratories, the change in doctor fees, and the reduction in the premium paid by the State under the new VSP plan resulted in a

significant impact on actual vision care benefits, or their cost to employees.

CDFF also argues that CP 8 demonstrates that coverage for eyeglass frames has changed significantly under the new VSP plan. CP 8 describes frame benefits under the prior plan as "$30 wholesale, control on extras," and as "$30 wholesale or $75 retail allowance" under the new VSP plan. However, this difference in the description of frame benefits does not in and of itself demonstrate that there has been a resulting significant impact on actual benefits received by employees. Crabtree testified that he had been told that the "control on extras" referenced in CP 8 under the prior VSP plan was actually a cap on the retail price providers could charge for frames - a cap of 250 percent of the wholesale price. Crabtree testified that under the new VSP plan the cap has been eliminated and there is no maximum on what a provider may charge for frames. However, Crabtree was unable to offer any support for his claim that "control on extras" actually defines a precise cap on the retail pricing of frames, so that assertion is rejected.

Neither the prior or new contracts between the State and VSP, nor the agreements between VSP and its participating providers, were introduced into the record, so it is not possible to review their specific provisions relating to the retail pricing of frames. CP 3 and CP 2 both make reference to frame pricing. CP 3, describing the VSP plan in effect on

June 30, 1998, indicates that frame costs will be limited "to cover the majority of frames in common use." CP 2, describing the new VSP plan, indicates that providers "are required to maintain a selection of frames which are fully covered under the your [sic] VSP plan." It can be concluded from these exhibits that there continues to be a cap under the new VSP plan on the retail prices providers can charge for frames, at least with respect to "a selection of frames." It cannot be concluded from these exhibits that there has been a change under the new VSP plan in the cap on retail frame prices which has resulted in a significant impact on employee costs of frames.

CP 8 also indicates a change in "frame coverage" from "Wholesale Difference X 2" under the prior plan, to "U and C minus $75" under the new VSP plan. The relationship of "frame coverage" to "frame benefits" described in CP 8 is unclear, as is the meaning of "wholesale difference." CDFF offers no explanation of the meaning of these descriptions and no evidence concerning the effects of any change, so no finding of a resulting, significant impact on actual benefits received by employees can be made based on these descriptions.

A review of this evidence relating to employee frame costs leads to the conclusion that benefits under the new VSP plan are very similar but not identical to benefits under the prior plan. However, it cannot be concluded from this evidence that the employee cost of frames has been impacted significantly by the

change to the new VSP plan. Consequently, CDFF's assertion to the contrary is rejected.

CDFF also points to a change in employee costs for cosmetic extras under the new VSP plan. CP 8 indicates that cosmetic extras were "dispensed at a controlled cost" under the prior VSP plan, while under the new VSP plan "usual and customary" is charged. Again, CDFF offers no explanation of the meaning of "controlled cost" or its relationship to a "usual and customary" charge, so it would be speculative to reach a finding of actual impact on the cost of benefits based solely on this language. Further, other exhibits suggest that a change in cosmetic extras costs would not significantly impact vision care benefits because coverage for cosmetic extras has always been extremely limited. CP 3, describing the VSP benefits in effect on June 30, 1988, includes the general statement that the plan "is designed to cover visual needs rather than cosmetic materials," and indicates that benefits for cosmetic extras such as lens coatings are limited. Specifically, the employee "will pay the additional laboratory cost for the extras plus a modest additional fee." CP 2, describing benefits under the new VSP plan, contains the same general statement concerning cosmetic extras and indicates that the employee "will be required to pay any additional costs associated with these extras." While the language is somewhat different, these exhibits clearly indicate that it is essentially the responsibility of the employee to pay for cosmetic extras under both the plan in effect on June 30, 1988, and the new VSP plan.

CDFF offers the testimony of Crabtree to bolster the claim of increased employee cost for cosmetic extras. Crabtree stated that the contract between VSP and participating providers mandated that employees be given a 20% discount on cosmetic extras under the prior VSP plan, and under the new plan the discount is not mandated. As noted, however, the contracts between VSP and its providers were not introduced into evidence, so Crabtree's assertion cannot be verified. Also, Crabtree's claim appears to be inconsistent with the limitation on cosmetic extras benefits described in CP 3 and CP 2. Crabtree further testified that in June 1996 he purchased an optional lens coating, a cosmetic extra, for $53 under the new plan. He testified that the lens coating would have cost him $44 before the change to the new VSP plan. Again, the record includes no documentation of Crabtree's purchase or of his assertion concerning the previous cost of the lens coating, so it is impossible to verify his claim. However, assuming the accuracy of Crabtree's assertion, the cost of a specific, optional lens coating, subject to the limited benefit for cosmetic extras, increased by $9 under the new VSP plan. The Board declines to conclude that this modest increase in the cost of an optional service, which could occur no more than once a year when eyeglasses are obtained, constitutes a significant impact on the actual vision care benefits received by employees.

The testimony and the documentary evidence fails to demonstrate that the actual vision care benefits received by

employees has been impacted significantly by a change in the cost of cosmetic extras under the new VSP plan.

CDFF also offers the testimony of Williams who paid "sixty-something dollars" in January 1995 for two pairs of glasses under the prior VSP plan and $73 in January 1997 for an eye examination and one pair of glasses under the new VSP plan. There is no documentation of Williams' purchases, so it is not possible to verify them or determine whether the materials and services he obtained in 1995 and 1997 were comparable. Williams testified that he was told by an employee at his doctor's office that the higher cost was due to an increase in the deductible. However, it is undisputed that the employee deductible under the prior and new VSP plans is identical - $10 for eye examinations and $25 for lenses and frames - so it is clear that any increase in the cost of the glasses purchased by Williams was not caused by an increased deductible.

A closer review of the evidence indicates that Williams' claim is quite problematic. An eye examination and a single pair of glasses would carry a minimum employee deductible of $35 in both 1995 under the prior VSP plan and 1997 under the new VSP plan. There is no coverage for a second pair of glasses under either plan. Assuming Williams paid $35 in 1995 for the pair of glasses covered by the VSP plan, his testimony indicates that he paid less for the second pair, even though the VSP plan afforded him no coverage for that second pair. Essentially, Williams' testimony raises more questions than it answers, and it is

difficult to draw specific conclusions from it without the benefit of any documentation of his purchases. In any event, it is clear that factors other than a change in the deductible led to the higher cost for glasses Williams may have experienced, but whether those factors were related to the change to the new VSP plan is unknown.

Reviewing the record as a whole, it is clear that vision care benefits under the new VSP plan are somewhat different than under the prior VSP plan. Specifically, there may be fewer frames available under the new plan which are fully covered by the vision care benefit after the employee pays the deductible. However, employees continue to have a selection of fully covered frames from which to choose. Also, there may be a modest increase in the price participating doctors are charging for some optional benefits such as cosmetic extras. However, payment for these options has always been the responsibility of employees so the impact on covered benefits appears minimal. It is also clear that major components of the vision care benefits received by employees, including coverage for eye examinations, lenses and frames and contact lenses, are either identical or substantially the same under both plans. As noted, minor adjustments in specific benefits offered under general health benefit CBA provisions are a normal occurrence. Accordingly, PERB requires a showing that such an adjustment has a significant impact on actual benefits received by employees before the Board will conclude that it constitutes a negotiable change. The evidence

presented by CDFF in this case falls short of meeting this requirement.

Summary

To prevail in this case, CDFF must present evidence of the impact on actual vision care benefits, or their cost to employees, which resulted from the State's action. The evidence CDFF presents is either speculative, insufficiently explained or unhelpful in demonstrating this impact. Therefore, CDFF has failed to meet its burden of showing that there has been a significant impact on the actual vision care benefits received by employees, or the employee cost of those benefits, resulting from the change to the new VSP plan.

ORDER

The unfair practice charge and complaint in Case No. SA-CE-891-S are DISMISSED WITHOUT LEAVE TO AMEND.

Members Dyer and Amador joined in this Decision.